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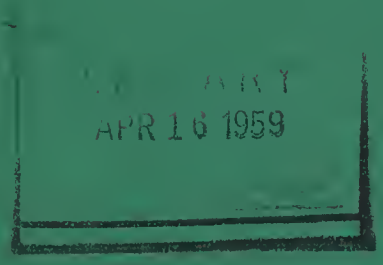
MARYLAND'S NURSING HOME PLAN



Committee on Medical Care
MARYLAND STATE PLANNING COMMISSION

February, 1959

Publication No. 103

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100 Equitable Building
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Director

March 20, 1959

Honorable J. Millard Tawes
Governor of Maryland
Annapolis, Maryland

Dear Governor Tawes:

I take pleasure in transmitting for your consideration a report of the State Planning Commission's Committee on Medical Care, entitled "Maryland's Nursing Home Plan." The study embraces a thorough analysis of the plan of the State Department of Health for nonprofit nursing home construction grants and nursing home payments.

Long concerned over a persistent shortage of nursing home beds for welfare and low income patients, the Commission believes that the current proposal offers a sound and forward-looking approach to the problem. Not only will the plan obviate the eventual necessity of the State entering directly into the nursing home field, but it will also diminish the future need for expansion of the State's chronic disease hospitals by enabling the earlier discharge of patients requiring nursing home care and releasing hospital beds for rehabilitation.

The report will, I believe, be greatly helpful in assessing the problem and the solution advanced by the State Department of Health.

Respectfully submitted,

Joseph Meyerhoff
Chairman

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1211 CATHEDRAL STREET
BALTIMORE 1, MARYLAND
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March 9, 1959

Mr. Joseph Meyerhoff, Chairman
Maryland State Planning Commission
100 Equitable Building
Baltimore 2, Maryland

Dear Mr. Meyerhoff:

I have the honor to transmit herewith a report entitled "Maryland's Nursing Home Plan." This study reviews the proposal which calls for nonprofit nursing home construction grants and for supplementary nursing home payments. This report has been approved by the Committee on Medical Care.

For some years, the Committee on Medical Care has been very much concerned over the shortage of nursing home beds for welfare and low income patients. We feel that the current proposal is a reasonable approach to solving this problem. It will encourage the development of needed facilities, and obviate the eventual need for the State to enter the nursing home business. It will, by enabling earlier discharge, open up needed chronic hospital beds for rehabilitation, and thus forestall requests to expand these hospital facilities. It will also free needed beds in our general hospitals.

It is our belief that this proposal will go a long way in answering Maryland's unmet medical care needs.

Sincerely yours,

(Signed) George H. Yeager

George H. Yeager, M.D.
Chairman

PREFACE

The increasing number of aged, with concurrent chronic physical disabilities and illness, and the inadequacy of funds to purchase needed services, have developed a social and medical problem of major proportions. The situation is not new but it is becoming more acute each year.

Nursing homes have mushroomed in the last twenty years, but the number of available beds has not kept pace with the growing need.

The State Department of Health has promulgated a two-phase program intended to resolve some of the problems faced by persons needing nursing home care.

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SUMMARY

The Need - In Maryland there is a serious need for nursing home beds for Welfare patients and those of moderate means. Beds are available to those financially able to pay prevailing rates; but many, while continuing as patients, experience a total depletion of their resources. Most have only pensions or insurance money which keep them above the eligibility scales for public assistance; others have nothing but a share of the income of their children. Rarely can any of these old folks pay the usual nursing home charges of $6 to $8 per day. Those who are eligible for Welfare grants are frequently refused admission to beds because the grants of approximately $3.75 per day are not considered adequate by the nursing home operators.

Inability to get into nursing homes leaves many patients where they do not belong - some at home where they are often perforce neglected, some in hospitals where their care is expensive and where they are occupying beds which are needed by acutely ill persons.

The Proposed Plan - The present plan consists of two parts. Each is aimed to make available more nursing home beds for Welfare patients and others of low or moderate incomes:

Part I - By new construction of non-profit homes through construction grants.

Part II - By making more beds available in both proprietary and non-profit homes through supplementary payments for patient care.

Construction Grants (see also page 7) - Five-hundred additional nursing home beds would be provided through the proposed construction grants during the next five years. They would be in homes operated by non-profit or public groups. Federal grants are already available, but this

proposal is to combine State funds with them so that the State and Federal monies together will cover two-thirds of the cost, leaving one-third to be raised by the home or by the group sponsoring the home.

The money for the State grants would be provided through a Bill "The Nursing Home Loan of 1959" to be introduced at the 1959 session of the State Legislature. A sum not exceeding $1,500,000 would be provided through a bond issue. The bonds would be authorized and issued only as needed on each building project. Grants would be made only to areas of greatest current need. No institution would be considered unless its sponsor agreed to accept a reasonable number of charity patients.

This plan to expand non-profit homes is aimed to keep the responsibility of operating the facilities on a local level and to enable patients to be near their families and friends.

Supplementary Payments (see also page 14) - The second part of the plan, that of supplementary payments, is complementary to the construction phase. It is aimed to bring about better utilization of existing nursing homes both proprietary and non-profit. Many homes have vacant beds which operators hold for patients who can pay established rates. The proposed additional payments would induce operators to admit more Welfare patients and put many of these vacant beds into use.

These payments would be made by the Health Department to nursing home operators. They would be in addition to the present grants of about $3.75 per day which are paid to the patient by Welfare; but, unlike the Welfare grants, they would be paid only on selected patients, those who need a special service and are located in homes having the facilities and staff necessary to provide the service adequately.

Only a small number of supplementary payments would be made during the first year, but these would enable the necessary administrative machinery to be set up and provide experience for estimating the total need and cost. The plan would operate as a Pilot Project and the supplementary payments would be made on behalf of patients who might, in the absence of some such plan, require chronic hospital care. The Health Department plans to pay these supplements out of its Chronic Hospital operating funds. Payments on an estimated 15 to 25 patients would require approximately $10,000 for one year.

PART I - CONSTRUCTION GRANTS

History - To provide more nursing homes, the Federal Hospital Construction Act has since 1954 provided for Construction Grants payable to the sponsors of non-profit and publicly operated homes. These have been available to cover one-third of the cost of the building and equipment, but so far only one institution has taken advantage of the funds allocated to Maryland. Numerous inquiries have been received, but the remaining two-thirds of the cost has been more than any home could provide. Last July the proportion payable from Federal funds was raised to 50%.

The Health Department has repeatedly urged State grants for nursing home construction. These would supplement Federal funds as a means of reducing the amounts which must be provided by the home or by a group planning a home. The recommendation for State grants has been supported by the State Planning Commission. Requests for grants have been placed before the 1957 and 1958 Legislative sessions, but they did not pass. The principal reasons for rejection were the uncertainty of the ultimate cost of the program and the absence of a long-range plan. The opposition of operators of proprietary nursing homes also played a part.

State Grants to Supplement Federal - The request for State grants will therefore come before the State Legislature for the third consecutive year. The past requests have been for Capital Improvement Budget Items of $100,000 to finance a one year trial of the plan. This amount was geared to the Federal funds then available. Recognizing the advantages of long-range planning as preferable to a one-year plan, the Health Department's present proposal is planned to cover five years.

Projected on the basis of the unmet need for nursing home beds, it is embodied in a Legislative Bill "The Nursing Home Loan of 1959." It is not a Capital Improvement Budget Item (under which funds would revert if not expended in 2 years).

While this Bill would make available $1,500,000 of State funds for matching Federal and local funds, bonds would be authorized and issued only as needed on each building project. The State's part of each construction grant would be realized from this loan and would be subject to rules and regulations promulgated by the Board of Public Works and by Public Health Service regulations governing the Federal Construction Grants.

The State and Federal contributions would total not more than two-thirds of the cost of the building and equipment; but the State and Federal would not necessarily be one-third each. One might be more, the other less. It is anticipated, in fact, that, to the extent that Federal funds are available, these will be used to cover one-half of the total cost. This would reduce the State's share to one-sixth. Whenever Federal funds were insufficient to cover one-half, the State grants would be increased as much as necessary to bring the combined State and Federal to two-thirds.

Amount of Construction - The number of additional nursing home beds which could be constructed through the combined usage of Federal, State and local funds is estimated at 500. These would bring the State's total, including all existing nursing home beds, to 1.5 per thousand population, the number recommended in Maryland's MEDICAL FACILITIES SURVEY AND PLAN*.

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* Published by Maryland State Planning Commission, April 1956.

The construction money would be provided over the five-year period from the following sources:

1.	Federal Funds, fiscal year 1959 (now available)...	$ 125,228
2.	Federal Funds, next 4 yrs. at $50,000 per yr. (estimated).....	200,000
3.	State Funds, proposed $1,500,000 Loan, 5 yr.....	1,500,000
	State and Federal (2/3 of total).....	$1,825,228
4.	Local Funds (1/3 of total).....	912,614
	Total.....	$2,737,842

At a cost of $5,000 to $6,000 per bed this would provide approximately 500 beds.

For the fiscal year 1959 Congress appropriated (for Maryland) $125,228 for non-profit and public nursing home construction under the Wolverton Amendment of the Hospital Construction Act. For several previous years the amount was $50,000. The 1959 figure, it is understood, came as an anti-recession appropriation. It is therefore assumed in the above calculation that Maryland should anticipate $50,000 in future years. If additional Federal funds become available in future years, the State's contribution would be reduced by an equal amount.

The Precedent for State Grants - Financial aid for nursing home construction is not a new concept. It was recognized in 1954 when the Federal Hospital Construction Act, through the Wolverton Amendment, included non-profit and public nursing homes among the institutions eligible

for Federal Construction Grants. By 1958 twelve States* had provided State funds to be added to Federal for the purpose of encouraging construction of medical facilities including nursing homes. It is proposed that Maryland do likewise.

What is the Procedure for Approving a Nursing Home Construction Project? - The State Board of Health, advised by its Hospital Construction Council, is authorized to award Federal grants for hospital construction. It has been doing this since 1948. Grants have been allocated in an equitable manner; that is, for construction projects in areas of greatest current need. The State Board of Health is authorized to award nursing home grants in the same way. No construction project would be eligible for a State grant unless it was also eligible for a Federal grant.

Priorities According to Areas - Highest priorities for nursing home construction grants would be given to applicants in counties which have the lowest number of beds in homes of suitable structure and design in proportion to the county's population. The meaning of the term "suitable" can best be shown by citing examples of unsuitable homes as quoted from Maryland's MEDICAL FACILITIES SURVEY AND PLAN:

(a) Multistoried frame buildings, even though provided with sprinklers

(b) Halls and/or stairs too narrow for convenient transportation of patients

(c) Remote from fire company (5 miles or more)

(d) Inadequate sewage system and/or water supply

(e) Access roads impassable at times

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* Alabama
Alaska
California
Georgia
Kentucky
Louisiana
Missouri
Nevada
New York
North Carolina
Tennessee
Virginia

At present there are 16 Maryland counties which do not have a nursing home which can satisfy the "suitable" criteria. They are given first priority in the distribution of construction grants. Washington County would have the lowest priority because it has 128 suitable beds out of a needed number (at 1.5 per thousand population) of 151. Areas with intermediate priorities are Prince George's County, Baltimore (City and County combined) and Carroll, Montgomery, Anne Arundel and Frederick Counties.

Priority will be given to institutions which offer the type of service most needed, and no project would be considered eligible unless it agreed to accept a reasonable number of charity patients.

Illustration - While a variety of types of institutions could well be utilized, the following hypothetical nursing home is given as an illustration of the kind which would best serve the community.

The nursing home would be sponsored by or affiliated with a general hospital, though it would not necessarily be located on the hospital grounds. It would have its own board of directors. A new building would be constructed. The building and equipment would cost $300,000; $200,000 from Federal and State and $100,000 (in addition to the site) from local sources. Assuming a construction cost of $5,000 per bed, the building would contain 60 beds.

Admissions would consist of patients discharged from chronic hospitals after completing maximum rehabilitation, those from general hospitals or from patients' homes after it was shown that chronic hospital care was not needed. Patients would be admitted because of their continuing need for skilled nursing care. Operated on the same policies as voluntary non-profit general hospitals, the home would accept patients

whose care was paid partly or wholly by Welfare; but it would also accept paying patients including those with small pensions or other incomes in excess of the public assistance eligibility scales but not having enough to pay usual nursing home rates.

A nursing home of this type would be comparable to Keswick, Jenkins Memorial and Levindale and would hold a highly respected position in its community. Local citizens would take an interest and many would render volunteer services. The board of directors would adopt policies geared to meet the needs for care. They would be willing to accept patients who, because of their condition could not arrange for satisfactory care elsewhere. These would include the seriously incapacitated patient who required much nursing time; patients hard-to-lift; those who are incontinent; those suffering from unhealed bed-sores or from advanced cancer; those unable to feed themselves; and those with cranky dispositions. Most proprietary nursing homes do not want these patients because of the added service required.

Cost of Operations - It would be optimistic and misleading to give assurance that a nnn-profit nursing home could balance income from patients with costs. A home, or a group of citizens planning a home, aimed to serve middle and low-income population groups should plan to have supplemental income to cover expected deficits. The income of the home as described above, would be derived from a combination of patient fees, Welfare grants, Health Department supplementary payments (see Part II) and donations. Additional county payments, similar to those now in effect in the general hospital Inpatient Program, while not available for nursing home care at present, could be justified since the home would be rendering a necessary service to the county's residents.

This financial plan would mean that, if a deficit occurred, the home could fall back on its community resources. This is done by voluntary hospitals. Dependence on community support should not be regarded as a weakness. Nursing home care of low income patients might well be considered a community responsibility and it is reasonable that a facility, established with a non-profit motive to carry out this responsibility, should depend in part on community resources.

Inquiries Regarding Grants - A number of potential applicants of new non-profit nursing homes are known to the Health Department. Inquiries have been received from:

(1) The Public Health Association of Caroline County

(2) Board of County Commissioners of St. Mary's County

(3) Maryland Branch of Kings Daughters and Sons who operate Southern Home and Hospital in Baltimore

(4) Volunteers of America Hospital in Baltimore

(5) A Soroptimist Club in Pocomoke City

(6) A group interested inbuilding a nursing home in Queen Anne's County

Representatives of several general hospitals have expressed an interest. If State grants are made available, it is expected that a number of groups will proceed with their planned construction programs.

Advantages - The principal advantages of the construction grant proposal are those of economy and of effectively meeting the needs for service. The nursing home is the most economical way to care for the patient who needs continuous nursing care. A shortage of them forces patients into more expensive facilities. The chronic hospital is twice as expensive. The general hospital is out of the question.

Some nursing home operators have no vacancies while others are unwilling to fill their empty beds with patients of limited financial resources or with those who have difficult nursing problems and cannot pay the cost of the necessary additional service. For the same reason other patients who need service and could be helped in a nursing home remain at their own home without proper care.

Nursing homes constructed under the proposed grants would provide a humane form of care because they would be near the patient's home and would be attractive through the many services rendered by volunteer groups. From a long-range standpoint this plan is basically sound because it places major responsibility on a local level, developes local participation and interest and does not propose to displace existing nursing homes.

PART II - SUPPLEMENTARY PAYMENTS

The second part of the Health Department plan to make more nursing home beds available is that of supplementary payments to nursing homes. The payments would be in addition to the money received by the operators from patients' public assistance checks. Unlike the Construction Grants they would create no new beds, but they would bring more existing beds (which are now held vacant) into usage by inducing operators to fill existing vacancies with public assistance patients.

Payments Would Be Individual - The new plan would not change the present public assistance grants (about $3.75 per day) to patients. The supplements would not be paid on behalf of all patients but only on those who would require more than the usual amount and kind of nursing service. Payments would be made under 2 conditions:

a. The patient would be in need of some special professional service.

b. The home would have facilities and skilled personnel required to meet the patient's needs.

Homes Eligible for Payments - While all licensed nursing homes would be considered as potentially eligible for supplementary payments, none would receive an authorization until it had submitted data on the qualifications of its personnel, its operating costs and its available facilities and until the Health Department had decided that the home was fully competent to render the service required by the patient. The final decision would be made on an individual patient basis according to the needs of the patient and the ability of the home to provide the service.

Pilot Project During the First Year - Only a small number of payments would be made during the first year, or "Pilot Project" phase. The purpose would be to set up the administrative machinery and gain experience for operating the program on a larger scale.

The Health Department proposes to begin with a few carefully selected patients, perhaps 15 to 25, for whom a special plan is urgently needed either as a substitute for admission to a chronic hospital or as a device for moving a patient out of a chronic hospital because he no longer requires a hospital level of service. In each of these instances the plan would have the effect of saving or releasing a chronic hospital bed for a patient who required hospital care. By starting out with these types of patients - those who would be potential chronic hospital problems - the Health Department is setting up the plan as an extension of its Chronic Hospital services and is proposing to finance the payments from monies of its Chronic Hospital Budget. Twenty patients with estimated supplementary payments of $30 to $60 per month would total $10,000 covering a period of one year.

The State Board of Health has requested that the project be implemented as soon as practicable. Requests are therefore being made to utilize currently available Chronic Hospital funds and to inaugurate payments as early as possible. The experience gained should be sufficient to formulate a more adequate plan and a budget request for the year beginning July 1, 1960.

During the first, or pilot year, all Welfare patients and all nursing homes would be reviewed in respect to the justification for supplemental payments. This should provide an answer to the important question of how much the program would cost if all Welfare patients who needed special service were eligible and if all, or nearly all, homes qualified for participation.

Cost of Nursing Home Care - It is anticipated that the study of costs will not be limited to the services covered by the supplementary payments but will show the approximate cost of adequately caring for the usual, or uncomplicated, nursing home patient. These studies would be conducted in cooperation with the State Department of Public Welfare and they should prove helpful in determining the adequacy of the present nursing home public assistance grants of approximately $3.75 per day.

Objectives - This plan would be an important step in solving the immediate problem of finding places for the difficult patients who need nursing home care. At present rates most homes are selective in accepting Welfare patients depending on the work load of caring for each one. The care of a difficult patient is more expensive and there is at present no way to pay the home more when this is the case. It is customary, on the other hand, to charge private patients higher rates if they need daily dressings, if they must be fed or if they require other special service.

If higher rates are offered, it can be expected that homes will accept difficult patients even though they will have to employ additional skilled staff. The special payments would thus provide a new type of incentive, an additional reason for keeping a well-qualified staff and concentrating on the patients who need their skills. Supplementary payments would in this way be conducive to raising standards. The nursing homes which care for substantial numbers of Welfare patients, a most important group in terms of the current problem, would be much affected, and these homes would find that the total income from the supplementary payments would go far toward offsetting the cost of better qualified staffs.

Adequacy of Welfare Grants - Supplementary payments are, of course, closely related to the adequacy of the basic Welfare grants to the patient. Nursing home operators have repeatedly complained that these payments are too low, and the Health Department has agreed that they are below the cost of fully adequate care.

In February 1956, when the maximum monthly payments were $90, the State Department of Public Welfare recommended an increase to $130. The Health Department supported this request and cited a cost study by the New Jersey Department of Welfare as a basis. The Maryland Legislature at that time appropriated funds for an increase to $120. This maximum rate is still in effect and applies to Baltimore City and six surrounding counties. In other counties, where the cost of living is lower, the rate is $110. These rates are limited to patients who require total nursing care. From each monthly check (to the patient) the patient is permitted to retain about $4.50 as a personal allowance; the rest is used as payment to the nursing home operator.

Amounts of Payments - Initially, the supplemental payments would be based on schedules developed from studies of costs of such services in nursing homes and chronic disease hospitals. An analysis of the time required for each service has already been made at the Montebello Hospital. Payment schedules would be revised as experience is accumulated.

Payments would be made in accordance with a list of fees for each special service. Examples of conditions needing special services are:

Open lesions requiring frequent dressing

Intravenous feedings

Feeding by an attendant

Training to use artificial leg

Periodic Review of Patients - Each payment would be authorized for a stipulated period, such as one, two or three months. Before the end of this time the Health Department would review the patient's condition and the services which he is receiving. A re-check would also be made of the personnel and equipment of the home. This periodic review would therefore be similar to the processing of the original authorization. If the patient's condition and the qualifications of the home justified extending the period of the special payments, this would be done; but if the patient no longer needed the special service or if the home no longer met the standards, the payments would be discontinued. An example of failing to meet standards would be that of a home which discontinued the employment of professional nurses.

Supplementary Payments Would Also Help the Non-profit Home - Both non-profit and proprietary homes would be eligible for the supplementary payments. The non-profit nursing home would benefit in two ways:

1. The home now operating and caring for Welfare patients would suffer less financial loss on these patients. These losses are serious financial hardships. The non-profit homes are giving a high-standard of care. They must make good a loss on each Welfare patient of $4 to $5 per day; i.e., the difference between Welfare payments and the cost of care.

2. To a citizen group contemplating the construction of a nursing home with the aid of Federal and the proposed State grants, the assurance that a high grade of nursing care would earn supplementary payments would facilitate the drawing up a feasible budget in spite of the admission of a reasonable number of Welfare patients.

Support of the Plan - The drafting of this plan followed the discussions at the General Assembly in February 1958 concerning the

Health Department's proposal for State Construction Grants. Nursing home operators at that time claimed that the problem of nursing home space was due entirely to the low payments for the care of Welfare patients. While the Health and Welfare Departments realized that these payments were low, substantially below the cost of adequate care, they took the position that any increase should be on a selective basis rather than a flat raise across-the-board. This train of thinking lead to the formulation of the present plan.

The State Board of Health on June 27 requested development of a plan to implement the recommendation of the State Planning Commission's Medical Care Committee to align payments for the care of Welfare patients to the needs of individual patients. The Health Department's Advisory Committee on Chronic Illness, as well as its Council on Medical Care, have endorsed the plan. The State Board of Health on November 21 asked that money be made available.

CONCLUSION

For several years Maryland has been striving to provide a network of services to meet the needs of the chronically ill. These range from the general hospital to supplementary home care services. The State's plan aims to place each patient in the service which meets his needs and to move him when his condition changes and requires a new service. But this system, sound as it is, cannot function if there is a shortage of any one type of service. Lack of one type forces patients into the wrong places. This is happening in Maryland now. Patients whose needs can be met in nursing homes, but cannot be placed there, remain in general hospitals, in chronic hospitals or in their own homes. For many years Maryland has had good general hospitals and it now has good chronic hospitals, but its nursing home facilities, except for medium and higher paying private patients, are inadequate. Nursing home care is only slightly less important than hospital care. The deficiency in this level of service is serious. It can be corrected only by vigorous measures.

It is recommended that more nursing home beds for indigent and medically indigent patients be provided:

a. In non-profit nursing homes through State Construction Grants to supplement the existing Federal Grants.

b. In both non-profit and proprietary nursing homes through supplementary payments for patient care.

February 1959.

APPENDIX

(DISCUSSION OF THE PROBLEM)

APPENDIX (DISCUSSION OF THE PROBLEM)

Shortage of Nursing Home Beds - The need for nursing home space is evident whenever an attempt is made to find a bed for a particular patient. Hospital social workers, and others who are frequently called upon to make arrangements, report that weeks or months frequently pass before a patient can be placed. Thirty-one out of thirty-eight general hospitals, who answered a questionnaire, reported difficulties in finding nursing home space for patients ready for discharge.

Examples of Problem Cases - Two cases, which recently came to the attention of the Health Department, illustrate the nursing home problem as it affects the family of moderate means:

> Case I, is a young single woman, employed as a secretary, faced with a decision about her mother who is in a general hospital. This elderly patient's acute illness was over but she was bedridden and needed care for the rest of her life. Her daughter, if she brought her mother home, would have to quit her job and stay at home. Without her wages she would have to apply for a Welfare grant. She therefore tried to place her mother in a nursing home, first obtaining a list of licensed homes from the Health Department, then searching for one which had an empty bed at a rate which she could afford. After 11 days, while her mother remained in a general hospital and the hospital bill went up, she located a nursing home bed and moved her mother into it. A little later, when asked about the arrangements, she said, "I am ashamed to say where I placed my mother, but it was the only place with a bed available at a rate I could pay - and I don't know how long I can do this and keep my own expenses paid."

> Case II, can be stated briefly. A man was supporting his aged mother in a nursing home at a rate of $56 per week. In a few weeks he would reach compulsory retirement, his income would drop and he would no longer be able to continue the nursing home payments. His inquiries at non-profit institutions revealed long waiting lists. He was in a dilemma to find a solution before his retirement.

Vacant Beds - It might be claimed that the existence of vacant beds in nursing homes proves that there is no shortage of space. It is true that vacant beds exist. Proprietary homes reported 295 vacant beds for white patients and 6 for Negroes on a Health Department Questionnaire last year. Only a few of these, however, were available for Welfare patients and for others who could afford only a low rate of payment. It is the shortage of beds for such patients which has caused a critical situation. Proprietors of homes are not bound to accept a patient when they have an empty bed. Some have fixed policies not to accept Welfare patients, others accept only a token number.

The over-all shortage of total nursing home beds is not apparent to the patient who is able to pay prevailing rates but the shortage is acutely felt by the Welfare client, the pensioner and the aged patient dependent on his children. When care is required over a prolonged period these people face the stark fact that they are unable to pay the prevailing rates of $6 to $8 per day.

Maryland's plan calls for 1.5 nursing home beds per 1,000 population. On the basis of the total existing beds, even counting the structurally unsuitable, there is a deficit of 423.

Number of Welfare Patients - County Welfare Boards are paying for nursing care for approximately 1,600 patients in various parts of the State. About 250 of these receive the payments for nursing care in their own homes; the rest are in nursing homes, mostly proprietary. Non-profit nursing homes and the infirmaries of homes for the aged care for a smaller number. Twenty per cent of these public assistance patients pay part of the cost of their care, but the care for the others is paid entirely by Welfare. In Maryland's proprietary nursing homes one-third

of the patients receive public assistance checks, but elsewhere in the United States public assistance recipients average one-half the total.

In last year's questionnaire operators reported 898 Welfare patients distributed among 83 proprietary homes. White patients numbered 604 in 76 homes. The 294 Negroes are in 7, most of them in 4 homes in Baltimore City. Only 2 counties have nursing home beds for Negro patients.

No estimate is available of the number of patients who are not receiving public assistance payments but who are paying relatively low rates through their own resources.

Distribution Over the State - Patients tend to locate in nursing homes near their families. Relatively few go to a home in another county. The distribution of white Welfare patients (judging by the location of the nursing homes) shows the highest concentration in Baltimore City. Southern Maryland counties by population show one-thirteenth as much usage of these facilities. Twelve of the seventeen Welfare patients in these four counties are in Calvert County, five in Prince George's and none in Charles or St. Mary's.

Nursing homes tend to locate according to the business interests of the owners. Few are operated primarily for Welfare patients and there is no assurance that homes will be located in all the areas where Welfare needs are high. Few homes locate in rural areas because of the small number of paying patients.

In last year's questionnaire 76 white and 7 Negro nursing homes reported that they had Welfare patients while 47 homes reported that they were not rendering this service. Forty-three of these 76 white homes, however, cared for only 1 to 4 Welfare patients. The 91 patients cared

for in them are too few to be an important factor in meeting the need. The big group of 604 white Welfare patients is divided about equally between 23 homes which care for 20 or more. Six of these 10 large homes are in Baltimore City and one each in Baltimore, Anne Arundel, Garrett and Washington Counties.

Chronic Hospital and Nursing Home Space are Related - Maryland's plan for the care of the chronically ill calls for more nursing home beds (1.5 per thousand population) than chronic hospital beds (1.0 per thousand). In areas where few nursing home beds are available as compared to the supply of beds in chronic hospitals, nursing home patients will, in spite of established admissions policy, find their way into chronic hospitals. This situation has developed in the nine Eastern Shore counties with their 250,000 population. Twenty-four Welfare patients are currently cared for in 10 of the 12 Eastern Shore nursing homes. By contrast 117 white and 54 Negro Eastern Shore patients are in Deer's Head Chronic Hospital at Salisbury and most of these are eligible for public assistance. These 171 Deer's Head patients were assumed to need chronic hospital care when they entered but many have markedly improved. About one-third of them are waiting for transfer to nursing homes. Shortage of nursing home space is the principal reason for keeping them at Deer's Head.

Quality of Care - In the licensing inspection of nursing homes it is not practicable to use a numerical score sheet to indicate the degree of compliance. Quality of care can be judged only by review of records over a period of time and by reports received from patients and relatives. In the homes which care for small numbers of Welfare patients standards vary but are similar in general to the homes which have no Welfare patients. Most of the homes which care for a preponderance of

Welfare patients, however, barely meet minimum standards. The quality of care is fair or less than fair. While meeting minimal standards required for physical plants, they are operated in a manner which is not a credit to the nursing home profession.

Why Not Provide More Space By Expanding Proprietary Nursing Homes? - The shortage of space for Welfare patients, nursing home operators say, is due principally to unreasonably low rates of payments by Welfare. Increase the payments and more space will be available.

Welfare payments would, first of all, have to be much higher to induce nursing home operators to do this. Payments would have to provide an attractive margin of profit so the owners would be willing to take the risks of adding to their plant investments.

If rates are raised, it is unlikely that they would be raised sufficiently to provide a profit to the nursing home operator. He would at best break even on public assistance cases. Therefore, to derive the necessary profit to continue his operations, he would have to give sub-marginal service to Welfare patients or include in his nursing home a large quota of profitable private patients. It is evident that no nursing home containing a significant number of public assistance cases would attract sufficient private cases to be operated successfully.

Rate increases, unless quite substantial, would not be a sufficient inducement to a proprietary operator to locate in an area where homes are scarce. He would conclude that this area would not attract private patients. The shortage of homes in these needy areas would continue.

The problem of inadequate buildings would not be solved by rate increases. Proprietary homes, almost without exception, do not

utilize fully fireproof structures. Common practice is to buy or rent large old residences poorly arranged for nursing care of groups of patients. These can be purchased for only a fraction of the cost of new construction. While operators make the old structures as safe as possible, much is left to be desired. Increased rates could not be expected to change this practice.

The Health Department has no objection to the raising of rates. Higher rates are recommended, but this action cannot in itself meet the needs of the large number of public assistance cases, especially those presenting difficult service problems.

Could the Nursing Home Type of Patient be Sent to the State's Chronic Hospitals as a Method of Making up for Shortages in Nursing Home Space? - The Health Department feels that this proposal would be both extravagant and unwise. The chronic hospitals were built to meet one aspect of the State's chronic illness needs - that of hospital service. Care in them costs twice that of the nursing home. The patients needing nursing home care make up a large group and the hospitals would have to be enlarged far beyond the 1064 beds which they will contain when the present building program has been completed in 1959.

To attempt to squeeze nursing home patients into chronic hospitals without expanding the hospitals would result in squeezing out the rehabilitation patients, those whom the hospitals can help most. Present policy is to admit two types of patients, those needing the hospitals for rehabilitation purposes (a larger group) and those suffering from non-rehabitable chronic illness who are too sick for nursing home care. The opening of the hospital doors to another group, those needing only nursing care, would have serious long-range consequences.

The wiser plan is to place the maximum number of patients in nursing homes and the minimum in chronic hospitals.

This usage of chronic hospitals would have other disadvantages. Patients would be taken far from their homes and families. They would receive fewer visitors. Relatives would feel less responsibility. Local communities would have no obligation. They would "resign" their nursing home responsibilities to the State. This plan would be financially, socially and politically unsound.

Could Nursing Homes be Operated by Counties? - A county could operate a nursing home and would be eligible for Federal construction grants and, if available, for State grants.

Nursing Home Operators - The operators of proprietary nursing homes have been opposed to construction grants. They claim that ample beds in proprietary homes will be available if rates are raised and "supplementatinn," (see below) is permitted. An increase in grants (an increase of $3 per day has been mentioned by one of their spokesmen) to a cost-plus-small-profit figure would provide the necessary beds, they say.

The Health Department agrees about raising rates (on a selected basis) but believes that more beds in non-profit homes are also essential in order to secure places for the hard-to-handle patients and to ensure the establishment of additional homes in areas where proprietary homes are not profitable.

It is obvious that the under-cost payments by Welfare have been a major factor in bringing on the shortage of beds. These rates should be revised upward and it is agreed that special payments according to the needs of individual patients and the qualifications of the homes, are

preferable to flat increases across-the-board. The difference in viewpoint between the nursing home operators and the Health Department is that the Health Department does not believe that increased payments alone will solve the problem. They will not induce proprietary homes to accept all of the patients, particularly the intensive-care ones, and they will not induce operators to establish homes in the needy areas of the State. The Health Department does not believe that all of the responsibility for caring for the indigent can be left to proprietary homes.

The term "supplementation," as mentioned by nursing home operators, refers to the acceptance by the operator of payments from the patient or his family in addition to the regular monthly payment from Welfare. The Department of Public Welfare has never permitted the supplementary payments but insists that any financial resources of the patient and family must be contributed in the place of part of the Welfare grant rather than added to it. This not only saves public money but follows the principle that if the established Welfare rate is sufficient for one patient it should be sufficient for another. Supplementation might seem justified if the Welfare payment is below cost, but in this case it would seem more logical to raise the Welfare rate to a reasonable figure and continue to disallow supplementation.

Proprietary operators have stated that they would not oppose construction grants if made only to homes which limited their services to the medically indigent. The Health Department does not feel that it can establish this limitation since the nursing homes will be operated independently. The restriction does not apply to Federal grants to either nursing homes or to other medical facilities including general hospitals. A non-profit organization, operating a nursing home as a

community service, would wish to accept, in addition to its fair share of charity patients, others of various financial levels. It would admit patients on the basis of their needs for the kind of service which it could provide. If it were forced to operate entirely on a charity basis, it would be branded as the place for the poor and any one going there would be considered a "pauper."

While nursing home operators have claimed that construction grants will give the non-profit homes an undue advantage over the proprietary, analysis indicates that this effect will not be appreciable. Non-profit homes, in applying for grants, must agree to take charity patients, not just a token number, but a number proportionate to the need. The home must be in an area where the need is great. The State Board of Health, acting on the advice of its Hospital Construction Council, is obligated to award grants where the need is greatest and is indirectly required to place public money where it will least affect the proprietary interests.

The amount of funds available for construction is too small to have appreciable affect on the nursing home industry. Five-years of grants, providing 500 beds, would provide a 15% addition to the State's nursing home space. The number of people needing nursing home care seems to be increasing faster than nursing home beds are coming into being. The proposed program is hardly more than a pilot project.